

Lib

CHARD RURAL DISTRICT COUNCIL.

A N N U A L R E P O R T

of

THE MEDICAL OFFICER OF HEALTH

FOR THE YEAR ENDED 31st DECEMBER, 1956.

PUBLIC HEALTH OFFICERS:

Medical Officer of Health:

A. M. McCall M.R.C.S., L.R.C.P., D.P.H.

Deputy Medical Officer of Health:

P. P. Fox M.B., Ch.B., D.P.H.

Public Health Inspectors:

E. Whisker M.S.I.A.
C. V. Muggeridge M.S.I.A.
G. H. Wheeler M.S.I.A.
T. A. J. Fowler M.S.I.A.

County Council's Health Visitor:

Mrs. O. J. M. Pitt S.R.N., S.C.M., H.V.

COMMITTEES concerned with matters of Public Health:

- (a) Public Health ... (19 Members).
- (b) Housing ... (19 Members).
- (c) Works ... (15 Members).



CHARD RURAL DISTRICT

-- in the --

COUNTY OF SOMERSET.

ANNUAL REPORT OF THE MEDICAL OFFICER OF HEALTH
FOR THE YEAR ENDED 31st DECEMBER, 1956.

To the CHARD RURAL DISTRICT COUNCIL.

Mr. Chairman, Ladies and Gentlemen,

I beg to submit my Annual Report for 1956.

There were a number of cases of measles in the first half of the year but there were no serious complications.

Unfortunately the School Dental Surgeon who was working in the area resigned at the beginning of the year and I have discussed the problem at length. It is particularly regrettable that, although occasional dental treatment has been available through the County Service for school children, so far no treatment has been provided for expectant and nursing mothers.

It is a statutory requirement for the Medical Officer of Health to produce an Annual Report for his area. The headings under which he reports are laid down and vary little from year to year. In an effort to avoid my reports becoming dull and uninteresting I try to increase their value by discussing current problems in the field of preventive medicine, and I hope the notes I have included on the causes of death, the Rh. factor, spastics, etc., will stimulate an interest in this year's report.

I wish to acknowledge the courtesy shown to me by the Public Health Committee and the Council during the year.

I am,
Your obedient Servant,

A. M. McCALL,

M.R.C.S., L.R.C.P., D.P.H.

Medical Officer of Health.

Health Department,
16, Church Street,
CREWKERNE, Somerset.
August, 1957.

CHARD RURAL DISTRICT

in the

COUNTY OF SOMERSET.

ANNUAL REPORT OF THE MEDICAL OFFICER OF HEALTH FOR THE
YEAR ENDED 31st DECEMBER, 1956.

SECTION A.

STATISTICS AND SOCIAL CONDITIONS OF THE AREA.

POPULATION:

The Registrar-General gives the estimated mid year population as 13,120, an increase on 1955. The general statistical details are given in Appendix A, Table 1.

BIRTH RATE:

The Birth Rate was 13.18 per 1,000. This is an improvement on the 1955 figure of 12.16. When the Comparability Factor (which allows for differences in the age and sex distribution in the district population and that of the United Kingdom) is taken into account, the figure is 14.23 which is below the national figure of 15.7 - the highest since 1950. There were five illegitimate births during the year. Appendix A, Table 2, gives full details.

DEATH RATE:

The Death Rate for the year was 10.97 per 1,000 compared with 11.68 for 1955. Allowing for the Comparability Factor this corrects to 10.02 - less than the national figure of 11.7. The causes of death are shown in Appendix A, Table 3. Diseases of the heart and circulation were again the greatest killers, having caused 71 out of a total of 144 deaths. Cancer came second, causing a total of 20 deaths.

Longevity, which means length of life, is a subject which has always held a great deal of fascination for the man who is impressed by long life in others and usually wants to achieve it himself. There are quite a few of these.

It is fair to say that the age at which one dies depends on how long one succeeds in avoiding death by accident or disease. Since we all die after a maximum of, perhaps a hundred and ten years, there must be a point beyond which no one can continue to escape the multifarious causes of death which compete for him. The Registrar-General recognises a large number of distinct causes of death, of which senility is only one and the question arises whether it is possible to die of old age as such. Has an individual a maximum capacity which limits his life so that he must die of a general wearing out of his tissues at an advanced age? The vast majority of human beings die of specific and identifiable failures of structure or function, and in a given year very few deaths have to be attributed to senility and other ill-defined causes.

Nevertheless, it could be argued that virtually all deaths other than those caused by accident or infection are in fact deaths of old age though not specified as such. These include deaths from degeneration of the heart and arteries and vascular lesions of the nervous system. In addition the age incidence of deaths from cancer allows a case to be made for it as a disease of ageing tissues, as it is essentially due to loss of control over what should be the normal replacement of tissue.

Mans' life seems to be limited to an average of something over 70 years, by which time most people succumb to failure of one system or another. Since a system which fails in one man at 70 may work well in another until something else kills him at 90 or in a third may fail at 45, there is reason to hope that simply by care and forethought man's average lifespan may be prolonged to come a little nearer the apparent maximum of 110.

Every year in England and Wales about half a million people die. If longevity is their aim, then some fall very early by the wayside. Losses are light in the age groups of childhood and youth, but from the age of 45 or so onwards casualties are very heavy and very few survive to do better than average in the 80s and 90s.

The first year of life in an immediate problem and danger. Then follows a period of comparative safety. Once 45 is reached men survive far worse than women. At 75 far more males die than females. The remarkable thing is not that so many women die at ages above 75, but that so many women survive to such advanced ages in this country when their male counterparts die between 45 and 75 in far higher proportion. It is well known that widows far outnumber widowers in England.

It is obvious that in considering the length of life of the ordinary man and the factors affecting it, we must look carefully at the causes of death involved.

Individual tissues have no specific time limit. Most people succumb to a failure, slow or sudden, of a particular system of the body. This may be fatal in itself, or fatal only because of the general senility of the body as a whole. The cardio-vascular system is the one which gives way most often. The general changes

which occur with ageing are partly known. The first effect of this is the loss of elasticity in the arterial walls. Most of the deaths due to this are caused by blood clotting in the constricted artery as in coronary thrombosis, where part of the heart muscle is deprived of its blood supply. A large number of deaths are due to the actual rupture of the artery as in cerebral haemorrhage. A non-fatal haemorrhage leads to the familiar stroke with varying degree of paralysis. There is a good deal of truth in the cliché that a man is as old as his arteries.

Some obvious changes which occur with ageing are deterioration in the functioning of the organs of special sense. In the eye, accommodation is slowly lost and the nearest clearly visible point recedes - the familiar figure of the ageing person holding the paper at arm's length. There is a decreasing range of hearing as age increases, particularly in the higher frequencies. Cerebral development, distinct from development of character and intellect, ceases in youth and the ability to learn decreases slowly, but is masked by the accuracy and wisdom which come with the accumulation of experience. On the whole, normal degeneration of the central nervous system does not affect the length of life though it affects the tempo at which it is lived. Although indigestion is common in older people, the digestive apparatus is very durable and can outlast the rest of the body in most cases. Renal function tends to become less efficient in old age.

Muscle power is usually retained at very nearly the youthful maximum until about 40. It drops slightly then and the drop becomes sharp in the 60s. The individual variations in the age and extent to which these changes occur are very great indeed, and many 40 year old men are genuinely senile while others in their 70s are well preserved and fairly youthful.

The individual glands have great durability and the system as a whole should easily last a century or more. Few people fail to reach old age because of a failure of the glandular system as such, but it is certainly linked with other systems which break down in old age. It may be that some overbalance of the glandular system can lead to a rapid failure of another system.

The respiratory system does not change greatly in old age except in its ability to resist and recover from infection. The lungs, unless subjected over a period of years to silica or coal dust, could outlast most of the rest of the body by many years if it were not for infection. Bronchitis and influenza mainly in old people cause a number of deaths and a failure of the respiratory system to resist infection. So an important factor determining the length of life is the definite lowering of resistance which comes with age and allows the body to be overwhelmed by an attack which it could have survived in youth.

In discussing deaths involving different organs and systems I have omitted deaths caused by cancer. Nearly all such deaths are over 45 years of age and it is one of the biggest stumbling blocks on the road to long life. The otherwise robust digestive organs are heavily involved. Cancer of the lung is not only the commonest cancer in man but one of the main killers of our time. Cancer of the reproductive organs strike women very heavily. Death rates from cancer, both in men and women, have increased in recent years, the greater increase being in males, mainly due to the increase in lung cancer. No special site could be singled out in females. It is important to note that the death rates and incidence rates of cancer in men and women are by no means the same thing. Cancer in men tends to strike in more inaccessible organs and to be less easily and early detected, while cancer strikes women chiefly in accessible organs and can be detected sooner. Cancer is an enemy of increasing importance and its grip more than counters the encouraging improvement in the death rate from infectious diseases. The defeat of diseases like diphtheria is a triumph, but it is overshadowed by the increasing menace of cancer.

To summarise I would say that man meets his death not because of any limit to the life of his individual tissues, but because the human body is so complex the body's tissues cannot be perfectly and indefinitely maintained in face of the stresses of normal life. Man seems able ideally to live to about 110, but deaths occur at all ages, mostly in the 60s and 70s. In the normal healthy body changes are continually taking place especially in the cardiovascular system so that hitherto non-fatal stresses and infections become more and more menacing and the eventual failure of one or more systems causes death. The increase in medical knowledge is continuously improving man's ability to ward off infections and recover from them and succeeding generations are living longer and longer. Old people form an ever increasing proportion of the population, but the increasing pace of life brings greater danger in the malignant disturbance of cell replacement called cancer and especially in failure of the circulatory system through the decrease of resilience to stress as age increases. It is against cancer and arterio sclerosis that the battle for longer life must be concentrated.

INFANT MORTALITY:

There were 4 cases of infant mortality during the year. One died of cerebral haemorrhage as a result of a difficult birth. The second died of T.B. meningitis, the third of toxæmia and the fourth due to infanticide.

MATERNAL MORTALITY:

There were no cases of maternal death during the year.

SOCIAL SERVICES:

The social services provided by the Local Health Authority remained unchanged during the year. The District Council made further progress with their provision of special housing for the aged.

SECTION B.

GENERAL PROVISION OF HEALTH SERVICES IN THE AREA.

There were no changes in the Rural District in 1956.

CARE OF MOTHERS AND YOUNG CHILDREN:

ANTENATAL CLINIC: Although no antenatal clinics are held in the Rural District mothers are able to attend those held in Crewkerne and Chard. The Medical Officer, myself in Crewkerne and Dr. Elliott in Chard, attend once per month for the purpose of taking blood samples for submission to the laboratory. The samples are examined as a routine for Wasserman and Kahn tests, haemoglobin estimation and the Rhesus reaction. The examination of the blood of expectant mothers is now a routine procedure in this area and is well supported by the local doctors.

THE RH. FACTOR: Many mothers these days say quite readily that they are Rh. negative or positive without knowing what they are talking about other than knowing it refers to a quality of their blood.

The Rh. factor is named after the Rhesus monkey used in the experiments which led to the discovery of the factor in 1940. The original work was done by Weiner in America.

It was found in World War II that many men following transfusion with blood of the correct group developed an unaccountable reaction. Levine showed that certain of these transfusion reactions were due to the Rh. factor.

The Rh. factor is a substance which 85% of persons have in their blood. This fact is most important to those remaining 15% whose blood does not contain the Rh. factor (Rh. - negative). When Rh. negative persons are given Rh. positive blood either by transfusion or through the common circulation of a mother and child during pregnancy, it may start the reaction. The person receiving the Rh. positive blood develops the antibodies to Rh. positive blood and as a result any subsequent transfusion or pregnancy may be attended by serious consequences. In the new-born the red blood cells breakdown and in the transfused jaundice may occur.

A baby's chances of suffering from this disorder vary considerably with the Rh. blood type of the parents and follow the Mendelian rules of inheritance. Since only a small proportion of all Rh. negative mothers are sensitised the general average of children born with this blood disorder is about 1 in 150. It is therefore a comparatively rare condition. The treatment is to transfuse the infant with compatible blood and the majority survive without any serious after effect.

When a mother is found to be Rh. negative a second sample of her blood is taken at the thirty-fourth week to see if there is a rise in the number of antibodies present, a sign that there may be trouble ahead. If it is thought likely that a transfusion will be necessary for the baby the mother is always admitted for her confinement to Musgrove Park Hospital, Taunton, where a specialised team is available. Should an unsuspected case occur in the district the nurse or general practitioner can always call on this team which act as a flying squad and will travel to any part of the County.

In addition to the Rh. test a second sample of blood taken at the same time is submitted to the haemoglobin test to detect any anaemia if it be present.

It is known that the haemoglobin or redness of the peripheral blood falls as pregnancy advances and probably true anaemia is present only if the percentage falls below 70%. However, it has been shown that if a daily supplement of iron is given the majority of women maintain a normal haemoglobin level throughout pregnancy. If this is done then they are more energetic and better able to face the rigours of their confinement and puerperium.

There is no doubt that anaemia of pregnancy can be prevented if patients will attend their antenatal clinics or see their own doctors in time so that any anaemia that develops can be efficiently treated. However, there are other factors in nutrition besides iron, and a good mixed daily diet which includes eggs, milk and meat should be aimed at.

DOMICILIARY MIDWIFERY: The District Nurses continued to attend expectant and nursing mothers in their homes, with the private practitioners supervising the cases. The practical service of delivery of the mothers and their after-care follow naturally on the work of the antenatal clinic. The mothers approach their time of confinement with the knowledge that they have been well cared for in the preceding

Digitized by the Internet Archive
in 2017 with funding from
Wellcome Library

<https://archive.org/details/b29097745>

DOMICILIARY MIDWIFERY (continued):

months. They have a sound knowledge of what is to take place, and they are well acquainted with the nurses who will be looking after them. All this leads to a feeling of calm confidence which is so essential.

HOSPITAL CONFINEMENT: Patients requiring hospital confinement on medical or social grounds are admitted to hospital in Yeovil, Taunton or Templecombe.

INFANT WELFARE CLINICS:

Merriott: This clinic is held twice per month and Dr. Amy Dauncey is the doctor in charge. It is well supported and reflects credit on the District Nurse and the Committee who support it.

Shepton Beauchamp: This clinic is held monthly. Dr. Munden, who was in charge, has now gone to Australia. I would like to record my thanks to him for the excellent work he did at this clinic for a number of years.

Tatworth: This clinic is held once per month and Dr. Elliott was in charge.

Winsham: This clinic is held once each month and Dr. Elliott is always in attendance.

Details of the various clinic attendances will be found in Appendix B, Table 1.

Apart from the immunisations and vaccinations she does, the doctor spends a great deal of her time allaying the mothers' fears which often have their origin in the folk lore handed down in families from mother to daughter. Such is the power of the matriarch that it may take many visits to the clinic before the doctor's advice is finally accepted without misgivings.

A strict timetable of ideas was necessary when welfare work started because infant mortality was so high and the first need being to save life, a life-saving rigid discipline was required. To-day many modifications of regime are suggested. Nevertheless a certain easy organisation is advised. The exponents of the modern doctrine of self regulation by infants often condemn the timetable in handling the baby. However, a young mother often worried and confused by a situation she has never before encountered is grateful for a simple routine which helps her to plan the management of the baby throughout the day.

As far as is practical breast feeding is advocated. The success of a mother in breast feeding her infants will depend on three simple things. It will depend on the kind and degree of antenatal care and tuition which the mother has received. It depends upon the psychological attitude of the mother, and thirdly it depends upon the composition of the individual mother's breast milk. Advice on all three of these factors are given at the clinic and the amount of breast feeding is to a certain degree a direct gauge of the effectiveness of the clinic.

Mothers have become obsessional about their children's weight and worry themselves sick if baby is putting on what they imagine is too little and occasionally too much weight. Frequently the problem is a simple one and advice is gratefully received.

Constipation is another constantly recurring problem presented at child welfare clinics. The Latin word 'stipare' means to press, and so far as derivation goes constipation means the passage of compressed, that is, hard stools. It is not what it is commonly assumed to be, synonymous with infrequent defaecation, though that is often accompanied by the passage of hard motions. Constipation is the delay in passage of material through the bowel resulting in the formation of hard stools, the passage of which gives discomfort.

The passage of hard stools is not always uncomfortable. There may be a great contrast between the anguish on the face of the mother as she hears the marbles rattle into the pot and the baby's smile of satisfaction.

Constipation has been considered harmful, but to-day it's ill effects are thought to be only the discomfort of defaecation. No longer is alimentary intoxication believed to be the result from constipation. Yet as a nation we are so pre-occupied about our regular bowel actions that we spend £70 million a year on purgative pills, tablets and salts. The symptoms of constipation are probably largely due to fear of constipation and this is partly the result of skilful advertising. 'You may be regular, but you may be a day behind' is a typical example. The fear may also be learnt from mothers who learn from their mothers: 'no stool, no school' was once a common morning threat.

Constipation often produces symptoms only because the person or parent expects it to do so. At school children are taught how their insides work and how to keep them working well. Earlier than this at the clinic, we try to ensure that, as infants, their bowel training is done without excessive anxiety on the mother's part. Good general advice on infant feeding is a good prophylactic against constipation in infancy.

The world is so full of a number of interesting things that it is a pity that people should spend an excessive amount of time, money and interest on how and what they are excreting.

HEALTH VISITING: The District Nurses and Mrs. Pitt act as Health Visitors for the area. Mrs. Pitt is also the Tuberculosis Health Visitor for the whole area.

The primary function of a Health Visitor is to visit the homes of the people and I am quite confident that at present this work is being done in a very efficient manner. This is particularly true in respect of the following-up of children with defects discovered at school medical inspections. None are overlooked, and if parents co-operate they will derive a maximum benefit from this part of the Health Service.

HOME NURSING: In addition to their many other duties, the District Nurses visit people's homes to carry out a very large number of duties. These may include dressing wounds, giving injections, bathing patients, and many other similar medical duties too numerous to list. A great deal of this work is concerned with the older members of the community, and we have every reason to be thankful for the kindly manner in which our Nurses have been working during the past year.

IMMUNISATION: During the year, the County Council as Local Health Authority, in co-operation with the District Council, took every opportunity to stress the need for immunisation against diphtheria and every means of publicity was used. Immunisations were carried out at all the Clinics and by myself in the schools. In addition to this, of course, there is a large amount of immunisation done by private practitioners, particularly primary immunisations. During the year 168 primary and 185 booster immunisations were carried out.

In 1956, following the success of the immunisation programme in the United States and Scandinavia, the Government launched a campaign for immunisation against acute poliomyelitis. It was commenced as a planned field trial and as the supplies of vaccine were very limited indeed, only a small percentage of children applying were in fact immunised. Only six were chosen from the Chard Rural District. I hope we shall be allocated some vaccine in 1957.

VACCINATION: In 1956, 85 primary and only 3 re-vaccinations were carried out. This is still not as many as I would like and I think that general practitioners might be able to help in this aspect of preventive medicine by persuading the parents of all infants to accept vaccination.

HOME HELP SERVICE: This service is organised by the County Council and was available in the district throughout the year. There was slightly less demand than in the previous year.

SCHOOL MEDICAL SERVICE: All schools in the area have been inspected by me during the year and details of these inspections can be found in Appendix B, Table 2.

SPEECH THERAPY: As reported last year, a number of children in village schools attend Crewkerne each week for training. Miss Henshaw is in charge of this clinic. Her work was most successful and undoubtedly her pleasant manner with the children has encouraged their confidence resulting in success in overcoming their disability.

Speech defects may be divided into two broad causes, mechanical defect and functional causes.

The mechanical defects are loss of hearing, a low intelligence quotient and poor control of the musculature of the tongue, lips and palate.

The functional causes are a history of poor speech in the family, imitation of another person with a defect, lack of speech stimulation when a baby. Two further completely opposite approaches by parents are also responsible for functional defects. One is the parent who will not allow the baby to pass through the normal stages of baby talk, e.g. bow wow, baa lamb. The other is the parent who does not encourage the child to grow up and as a result the child tends to return to the infantile level of speech to gain attention from the mother.

These are problems which the speech therapist has to deal with when a child is referred. It is obvious she must find the cause before commencing the treatment. The accuracy of her diagnosis is reflected in the success of her clinic.

BREATHING EXERCISES CLINIC: These clinics are now held at Crewkerne and Chard each week and children from our district are able to attend there. The Health Visitors supervise the exercises at every clinic and explain the idea and method to the parents who attend with the children. The Medical Officer attends once a month to assess progress and to see all new cases and discharge those who have learnt how to control their breathing.

SCHOOL DENTAL SERVICE: Unfortunately the Dental Surgeon appointed to the area left the County Service at the beginning of the year and was not replaced.

Now more than ten years after the war and eight years after the institution of the National Health Service there are a host of problems for dentists both as individuals and as a responsible group.

SCHOOL DENTAL SERVICE (continued).

Probably the most worrying features of the problem are these :-

1. Britain is only very slowly improving the general standards of oral hygiene;
2. There are too few dentists available at present, especially in the school and public dental services;
3. There are too few applicants of the right type to the dental schools of Britain.

Now, as never before, people are developing a taste for good dental care.

The adult population of this country had just started to realise how poorly it looked after its own and its childrens' teeth when the alteration in payment scales combined with a shortage of dentists to slow down the valuable work which had started. Financial stringency in the public and private purses has rendered more refined conservative and orthodontic work a luxury which is increasingly more hard to support. Though individual dentists produce work of the highest possible standard, generally the National Health Service can only guarantee a bare service of extraction and simple conservative work. The finer and more skilled works which are the technical delight of the good dental surgeon are now under a cloud of mistrust and disapproval - from the patient because of cost and from the Dental Estimates Boards because they view such work as luxurious. In this area the need for a specialist in orthodontics is obvious. The dental practitioner can rarely afford time for work that is inevitably slow and exacting and which may only yield a poor financial reward in proportion to his labour. Yet many children need an orthodontic opinion and treatment and the nearest specialist is either at Bristol or Plymouth.

The shortage of school dentists is even more alarming. The shortage is understandable enough when it is realised that they are the poorest paid of all the profession. One can understand the way in which most newly qualified men go into practice as soon as they can, leaving the financially barren field of childrens' dentistry to enthusiasts who are happily undisturbed by consideration of their bank balances. Thus the majority of dentists go straight into practices where for the rest of their working lives they work hard and continuously for a good salary.

The present dental surgeon has an education which is almost as long as that of the doctor. The present world wide shortage of dentists leads one to ask whether a simpler form of training, such as the New Zealand dental nurse scheme would not produce a larger number of adequately equipped people to cope with routine work. I think it would be a justifiable step to introduce some modified course of training so that dental auxiliaries can come into being in order to ease the dental surgeon's burden of routine and less skilled work. Such people could help in the provision of an efficient school service provided they worked under the supervision of fully trained dentists.

At present, due to the shortage, the most severely hampered is the school service and a practical way of overcoming the difficulty could be a scheme similar to that whereby hospitals ensure an adequate supply of house officers. A case can be made on grounds of educational desirability and practical expediency for the institution of a pre-registration year for the dentist. He could spend his year either in hospital appointments or in the school dental service.

The General Dental Council is concerned at the poor numbers and quality of the candidates at dental schools. It is certain that maintenance of high professional standards will only be possible if they make it clear that no reduction in professional status can be contemplated. Recruits of the type who are wanted in the profession will not be tempted to join if they see any relaxation of the standards or loss of prestige. The dental surgeon must continue to take his place beside the doctor as a man having a broad medical education as well as the necessary technical skill. If, however, some of the routine work can be passed by the dentist to a new type of technician, I feel that the profession would gain as a whole.

OPHTHALMIC SERVICE: At each school medical inspection I examine every child who has any eye defect whatsoever. I check the correction of their glasses and also check upon whether or not they are carrying out the directions issued by the Ophthalmic Specialist at the last appointment. If glasses are in need of repair or the correction does not satisfy me, I refer the child back to the person who made the glasses, and in some instances to the County Oculist who holds a weekly clinic especially for school children, at Yeovil and Taunton Hospitals.

Whenever I visit a private school I am struck by the few children who wear glasses as compared with the numbers in a comparable County School. This is not because there is a significant difference between the standard of vision in the two types of school. It is because in the County School regular routine medical inspection is carried out and the defects noticed at an early age. Undoubtedly many visual and indeed other defects remain undetected in schools where the children do not have the benefit of regular medical inspection.

ORTHOPAEDIC SERVICE: When necessary, children are referred to Orthopaedic Surgeons who hold clinics at Yeovil and Taunton. Reports and recommendations by the Specialists are forwarded to me as the School Medical Officer, and I see such children at each medical inspection and more often, if necessary. Most of the cases which require operation are admitted to Bath Orthopaedic Hospital.

A clinic is held once per month at Crewkerne and Chard where the Orthopaedic Sister supervises the follow-up of cases resident in that part of the Rural District.

PHYSIOTHERAPY: A physiotherapy clinic is held in Crewkerne two whole days per week. Many patients from the Rural District attend. This is a service provided by the Regional Hospital Board but it is obviously of necessity to the local Public Health Committee, in that it is a service which increases the speed of recovery of persons who have had bone and muscle injuries, and in addition gives a great deal of relief to the older members of the population suffering from rheumatic and arthritic conditions.

EPILEPTICS: Any cases of epilepsy occurring in the area are referred to a Specialist at Taunton who is able to carry out electro-encephalogram and other necessary investigations and then advise on the correct course of treatment. A copy of his report is always available to the School Medical Officer if the patient be of school age. Where it is considered necessary for a school child to attend a special school on account of the disease, it is possible to have them admitted to the Chalfont Colony where the Somerset County Council maintain a certain number of students.

SPASTICS: During the last few years there has been realisation by the public that there should be greater provision for the education and treatment of spastic children. The term is frequently used but few know its significance.

What is a spastic? Most children learn to eat, walk, talk, sit and stand without trouble. Such acts become easy to them because their muscles work together and they have control of them. A child with cerebral palsy (brain palsy) does not have control of all his muscles. As a result he often finds it difficult to do the simple acts of life. He may reach for a cup or pencil; as his hand moves it may miss the mark; he may knock over the cup or drop the pencil. Another child with cerebral palsy may not be able to walk straight. He seems to get off balance; he may stagger, reel and weave about. Another child may have trouble with his throat and tongue. If he tries to talk the sounds are often grunts and noises. The muscles of his face may twist and work. Seeing a child making faces and hearing the sounds he makes, give some people a wrong idea. They connect such acts with being feeble-minded because some feeble-minded children act that way. This may be far from the truth. Some of them are very bright. Some, it is true, are feeble-minded but it is not possible to tell just by the way children with cerebral palsy look or act. Mentally the large number of them are about like other children.

The cause is sometimes due to brain damage while the baby is being born. This may be when the mother has a hard and long labour but it is not necessarily the case. It may happen with an easy birth. Sometimes cerebral palsy may happen after birth and it has followed whooping cough, measles and meningitis.

A large number of spastic children do improve, others do not improve so much, still others not at all. Due to severe mental or physical disability some may have to be cared for in an institution for years.

It is important that all children with cerebral palsy should be under medical care and have opportunities for suitable education just as any other child.

BLIND PERSONS: There are 26 blind persons and 2 partially sighted persons in the area. No cases of ophthalmia neonatorum were notified during the year.

AMBULANCE SERVICE: The Somerset County Ambulance Service covers the area from their Taunton and Yeovil depots. The service worked quite smoothly throughout the year. In addition at night and at week-ends the area is covered by The Red Cross Ambulance in the charge of Mr. Sutton from Crewkerne, the Red Cross Ambulance in the charge of Mr. E. G. Farr at Ilminster and the St. John's Ambulance in the charge of Mr. Brooks in Chard.

SECTION C. PREVALENCE OF AND CONTROL OVER INFECTIOUS AND OTHER DISEASES.

One hundred and thirty-two cases of measles were reported in 1956. They were equally divided between January and February and July and August. No serious complications occurred.

Only one case of infantile paralysis occurred and the child made a complete recovery.

The case of Tuberculous Meningitis was a boy who was a visitor to the area for three days. He was admitted to hospital from our district and subsequently died. He was the son of a tuberculous father and had not received B.C.G. vaccination.

While the Mass X-Ray Unit was in Chard, a number of our residents took advantage of the opportunity and had a chest X-ray. In addition all the pupils of the Chard Secondary Modern School were X-rayed following the discovery of a case of pulmonary tuberculosis in one of the pupils. I am pleased to say no further case was discovered.

Details of both visits of the Unit will be found in Appendix C, Table 2. It must be realised that the figures relate to both the Borough and Rural residents.

In December the County Medical Officer announced the arrangements for the routine vaccination of school children against tuberculosis. It was decided to offer B.C.G. vaccination to all children born in 1943, that is children about 13 years of age. These would then have at least 18 months at school after vaccination and this would allow time to check whether immunity had been conferred and if necessary re-vaccinate. In Somerset the routine B.C.G. vaccination of school children will be carried out by County Staff only and not by general practitioners.

FOOD POISONING: A small outbreak of gastro-enteritis occurred at Ashill Primary School in April. Eight children were affected. The cause was not discovered but a full report of the investigation together with a recommendation was forwarded to the County Medical Officer.

SECTION D.

ENVIRONMENTAL HEALTH SERVICES.

(a) SANITARY CIRCUMSTANCES:

Climatic Conditions: A total of 24.29 inches of rainfall was recorded in 1956. A very dry spring was followed by a wet and disappointing summer. The winter was not severe.

Water Supply: The water supply was quite satisfactory both in quality and quantity and no shortage was experienced during the year. Details of the chemical and bacteriological reports will be found in Appendix D, Table 1, together with other relevant data concerning the distribution of the supply.

Extensions: The main between Chilworthy Lodge and the Langport R.D. boundary at Ashill was completed early in the year at a total cost of about £20,000. A 1" extension to Hinton Place, Hinton St. George, was completed at a cost of £328. A 4" main extension to Buckland St. Mary and Blackwater (the subject of a Ministry Enquiry) was commenced. The cost will be £12,500.

Sewerage: There was no change in the number of parishes with a main drainage and efficient disposal system. A 6" sewer extension to Hitchen, Merriott, was completed at the end of the year.

(b) FACTORIES ACT:

During the year inspections of premises under the Factories Act were made and details of this work will be found in Appendix D, Table 2.

(c) HOUSING:

Appendix D, Table 3, gives details of the housing situation. During 1956 the Council mainly considered plans to replace sub-standard property with new houses. In order to emphasise the urgency for this work, the Government have withdrawn the subsidy from council houses with the exception of those which are intended to replace slum property. They also publicised the details about improvement grant facilities under the Housing Acts of 1949 - 1954.

(d) INSPECTION AND SUPERVISION OF FOOD:

Milk: There is one registered distributor in the area and one dairy premises registered for the same purpose. A supplementary licence was issued to a distributor whose dairy is outside the area. Inspection of these premises and sampling of milk is carried out by the County Council and reports are directed by the County Analyst.

Ice Cream: No Ice Cream is manufactured in the Rural District, but 30 premises are registered for the sale of pre-packed products. It is regretted that no sampling was done during the year and steps are being taken to remedy this.

Meat: There are 11 licensed slaughterhouses in the area. These are widely scattered and under the present legislation the only requirement is for the slaughter man to give 3 hours' notice of his intention to slaughter. This time seldom, if ever, coincides with slaughtering in another nearby slaughterhouse. The result is that meat inspection is time-consuming and involves a considerable amount of travelling. Appendix D, Table 4, gives full details of the inspections carried out.

Licensed Premises: Before the Brewster Sessions at Ilminster all the premises which are licensed by that Court were inspected. A list of defects was sent to the Brewers concerned and a copy was sent to the Licensing Magistrates for information. At the end of the year just before the next meeting of the Brewster Court a further inspection was carried out. Most of the defects had been remedied and those outstanding were noted and the Brewers again informed. I arranged to attend the Court to discuss these with the Magistrates.

Food Premises: In 1956 the Public Health Committee concentrated their efforts on the improvement of hygiene of all food premises in the area. In order to ensure that the same standard of hygiene obtained in the Rural District as in the neighbouring districts we sent representatives to a combined meeting in which the new Food Hygiene Regulations were discussed. As a result the Public Health Officers of all districts in this part of Somerset interpret the Regulations in the same way and thus avoid anomalies. The Council also sent a precis of the Regulations to every food trader so that there should be no possibility of their being unaware of their obligations. Routine inspection of all food premises was proceeding at the end of the year.

APPENDIX A, TABLE 1.

Registrar-General's Estimate of population mid 1956	...	13,120
Area:	...	54,600 acres.
Number of inhabited houses at the end of 1956 according to the Rate Book	...	4,052
Rateable Value	...	£88,631
Sum represented by a penny rate, 1955-56	...	£208. 6. 11d.

APPENDIX A, TABLE 2.

BIRTH RATE:

Comparability Factor 1.08

<u>Live Births:</u>		M.	F.	Total.
Legitimate	...	100	68	168
Illegitimate	...	1	4	5
Total		101	72	173
<u>Stillbirths:</u>				
Legitimate	...	3	1	4
Illegitimate	...	-	-	-
Total		3	1	4
<u>Deaths of Infants under 1 year:</u>				
Legitimate	...	2	1	3
Illegitimate	...	-	1	1
Total		2	2	4
<u>Deaths of Infants under 4 weeks:</u>				
Legitimate	...	1	-	1
Illegitimate	...	-	1	1
Total		1	1	2

APPENDIX A, TABLE 3.

DEATH RATE:

Comparability Factor 0.93

<u>Causes of Death:</u>		M.	F.	Total
Heart:	Coronary Disease	16	4	20
	Other heart Disease	12	10	22
Circulation:	Vascular lesions of nervous system	9	18	27
	Other circulatory diseases	2	2	4
Cancer of:	Stomach	2	-	2
	Lung	1	-	1
	Breast	-	2	2
	Other sites	10	5	15
Lungs:	Tuberculosis	1	1	2
	Influenza	-	3	3
	Pneumonia	5	-	5
	Bronchitis	7	2	9
	Other respiratory diseases	2	-	2
Duodenal Ulcer		-	2	2
Nephritis		1	-	1
Congenital malformation		1	1	2
Syphilitic disease		1	-	1
Meningococcal infections		1	-	1
Other infective parasitic diseases		-	1	1
Leukaemia		-	1	1
Other ill-defined diseases		6	5	11
Motor vehicle accidents		3	-	3
Other accidents (excluding motor vehicle)		3	1	4
Suicide		2	-	2
Homicide & operations of war		-	1	1
Total		85	59	144

APPENDIX B. TABLE 1.

CHILD WELFARE CENTRES.

Statistics for the twelve months ended 31st December, 1956.

		Shepton Beauchamp.	Tatworth.	Winsham.
1. Number of children who first attended during the year and who at their first attendance were :-				
Under one year of age	...	18	16	9
2. Number of children who attended during the year and who were born in :-				
(a) 1956	...	14	12	5
(b) 1955	...	11	14	4
(c) 1954-51	...	30	46	17
3. Total attendances during the year made by children who at the date of attendance were :-				
(a) Under one year of age	...	126	96	38
(b) Over one but under two years of age		49	83	26
(c) Over two but under five years of age		119	103	45
4. Number of individual mothers who attended during the year	...	48	54	20
5. Total number of sessions held:-				
(i) With Medical Officer	...	12	11	11
(ii) Other sessions	...	-	1	1
Number of children examined by doctor	...	40	53	17
Total number of medical consultations	...	121	126	44

APPENDIX B. TABLE 2.

Name of School.	No. on Roll.	No. in- -spected.	Date of inspection.	Children having		No. Immun- -ised.
				milk.	dinner.	
Ashill	19	14	12. 9.56	94.74%	68.74%	-
Broadway	43	26	18.10.56	94.42%	65.12%	
Buckland St. Mary	33	27	8.11.56	96.97%	87.88%	11
Chaffcombe	38	20	27. 9.56	100%	71.05%	5
Chillington	38	20	27. 9.56	94.74%	94.74%	3
Combe St. Nicholas	67	51	14/19.11.56	83.58%	44.78%	33
Donyatt	26	6	20. 9.56	92.30%	61.54%	2
Hinton St. George	68	19	17. 1.56	92.79%	52.94%	-
Horton	57	30	24.10.56	96.49%	59.65%	18
Ilton	81	41	12. 1.56	96.29%	56.79%	-
Merriott	120	55	25.10.56	83.33%	23.33%	24
Misterton	52	17	17. 1.56	100%	30.77%	-
Seavington	27	16	6. 3.56	96.29%	100%	-
Shepton Beauchamp	59	26	15.11.56	93.22%	54.24%	4
Tatworth	124	57	11.10.56	93.55%	32.26%	9
Wambrook	17	14	13. 9.56	82.35%	58.82%	8
West Crewkerne	43	26	12. 3.56	100%	90.69%	-
Whitestaunton	16	11	2.10.56	100%	81.25%	12
Winsham	86	47	8. 3.56	97.67%	70.93%	-

APPENDIX C. TABLE 1.

INFECTIOUS AND OTHER NOTIFIABLE DISEASES.

<u>Disease.</u>			<u>Total cases notified.</u>
Measles	...	...	132
Scarlet Fever	...	...	5
Whooping Cough	...	...	6
Acute Poliomyelitis	...	...	1
Gastro-Enteritis	...	...	9

ANALYSIS OF CASES NOTIFIED.

	<u>Under 1 yr.</u>	<u>1-2.</u>	<u>2-3.</u>	<u>3-4.</u>	<u>4-5.</u>	<u>5-10.</u>	<u>10-15.</u>	<u>15-20.</u>	<u>20-35.</u>	<u>35-45.</u>	<u>45-65.</u>
Measles	1	5	7	13	11	81	11	1	2	-	-
Scarlet Fever	-	-	-	-	1	3	1	-	-	-	-
Whooping Cough	-	1	1	2	-	2	-	-	-	-	-
Gastro-Enteritis	-	-	-	-	-	8	-	1	-	-	-
Acute Poliomyelitis	-	1	-	-	-	-	-	-	-	-	-

TUBERCULOSIS.

<u>Age Group.</u>	<u>New Cases.</u>				<u>Deaths.</u>			
	<u>Respiratory.</u>		<u>Non-Respiratory.</u>		<u>Respiratory.</u>		<u>Non-Respiratory.</u>	
	<u>M.</u>	<u>F.</u>	<u>M.</u>	<u>F.</u>	<u>M.</u>	<u>F.</u>	<u>M.</u>	<u>F.</u>
- 1	-	-	-	-	-	-	-	-
1 - 5	-	-	1	-	-	-	-	-
5 - 15	1	-	1	-	-	-	-	-
15 - 25	1	-	-	-	-	-	-	-
25 - 35	2	-	1	1	-	-	-	-
35 - 45	-	-	-	-	-	1	-	-
45 - 55	-	-	-	-	-	-	-	-
55 - 65	-	-	-	-	1	-	-	-
65+	-	-	-	-	-	-	-	-
<u>Total</u>	4	-	3	1	1	1	-	-

APPENDIX C, TABLE 2.

MASS RADIOGRAPHY.

Report of Survey at Holyrood Secondary Modern School, Chard.

3rd - 5th July, 1956.

			<u>Male.</u>	<u>Female.</u>	<u>Total.</u>
Miniature Films	...	...	216	169	385
Large Films	Total recalled	...	1	4	5
	Did not attend	...	-	-	-
	Normal ...	...	-	2	2
	Significant	...	1	1	2
	Being investigated	...	-	1	1

Analysis of Tuberculous Cases.

Active Tuberculosis	Under 15 years	...	-	-	-
Under observation	" " "	...	1	-	1
Inactive Tuberculosis	" " "	...	-	1	1
Total No. of Scholars X-Rayed			204	162	366
Total No. of Staff X-Rayed			12	7	19

Report of Survey at The Health Centre, Chard.

12th - 19th October, 1956.

Miniature Films	...	...	830	599	1429
Large Films	Total recalled	...	19	12	31
	Did not attend	...	-	-	-
	Normal ...	...	7	8	15
	Significant	...	9	3	12
	Being investigated	...	3	1	4

Analysis of Tuberculous Cases.

Under 15. 15-24. 25-34. 35-44. 45-59. 60 + Total.

Active Tuberculosis:

Male:	-	1	-	-	-	-	1
Female:	-	-	-	-	-	-	-
Total	-	1	-	-	-	-	1

Under observation:

Male:	-	-	1	-	1	-	2
Female:	-	-	-	-	-	-	-
Total	-	-	1	-	1	-	2

Inactive Tuberculosis:

Male:	-	-	1	-	-	-	1
Female:	-	-	-	1	-	-	1
Total	-	-	1	1	-	-	2

APPENDIX D, TABLE 1.

WATER SUPPLY.

Piped Supplies - results of samples taken for Analysis:

<u>Raw Water.</u>				<u>Treated after going into Supply.</u>			
<u>Bacteriological.</u>		<u>Chemical.</u>		<u>Bacteriological.</u>		<u>Chemical.</u>	
Satis- -factory.	Unsatis- -factory.	Satis- -factory.	Unsatis- -factory.	Satis- -factory.	Unsatis- -factory.	Satis- -factory.	Unsatis- -factory.
5	-	4	-	1	-	-	-

Water Supplies from Public Mains:

<u>Direct to Houses.</u>		<u>By means of Standpipes.</u>	
<u>No. of Dwelling- -houses.</u>	<u>Population.</u>	<u>No. of Dwelling- -houses.</u>	<u>Population.</u>
3005	No record	50	No record.

APPENDIX D, TABLE 2.

FACTORIES ACT, 1937.

Inspection for the purpose of provisions as to Health (including inspections made by the Public Health Officer).

<u>Premises.</u>	<u>Number on Register.</u>	<u>Inspections.</u>	<u>Written Notices.</u>	<u>Occupiers prosecuted.</u>
Factories in which Sections 1, 2, 3, 4 and 6 are to be enforced by Local Authorities:	7	15	-	-
Factories not in- -cluded in (i) in which Section 7 is enforced by the Local Authority:	28	40	-	-
<u>Totals</u>	35	55	-	-

Cases in which defects were found	...	...	Nil.
Cases in which defects were remedied	...	...	Nil.

OUTWORKERS.

No. of outworkers in August List required by Section 10	...	...	...	245
--	-----	-----	-----	-----

APPENDIX D, TABLE 3.

HOUSING.

Total number of permanent dwellings in District	...	...	4,248
Total number of permanent dwellings owned by Local Authority	...	...	715

	<u>1955.</u>	<u>1956.</u>
Estimated number of houses unfit for human habitation (As per Ministry Circular 55/54)	100	96
Action taken during year:-		

1. Number of houses in Clearance Areas for which		
(a) Clearance Orders have been made	...	16
(b) Compulsory Purchase Order made	...	-
(c) Purchased by agreement	...	-

<u>Totals</u>	<u>100</u>	<u>112</u>
---------------	------------	------------

2. No. of houses included in Clearance Areas still to be made	...	16	-
3. No. of houses in Clearance Areas which have been patched for temporary accommodation under Section 2 of the Housing Repairs and Rents Act, 1954	...	-	-
4. No. of houses demolished under Section 25 of the Housing Act, 1936	...	-	-
5. No. of houses demolished under Section 11 of the Housing Act, 1936	...	5	4
6. No. of temporary dwellings (huts, etc.) demolished	...	19	-
7. No. of houses declared unfit under Section 9 of the Housing Repairs and Rents Act, 1954	...	-	-
8. No. of houses closed as a result of an under-taking given by the owners or following the issue of Closing Orders	...	17	-
9. No. of unfit houses occupied under licence	...	-	-

<u>Houses erected during year.</u>		<u>Houses in course of erection.</u>		<u>Gained from conversion of large houses or buildings into flats or dwellings.</u>	<u>Lost from conversion of two or more houses to one.</u>
For Slum Clearance.	For other purposes.	For Slum Clearance.	For other purposes.		

Local Authority	1	29	13	14	-	-
Private Enterprise	-	32	-	20	-	-

No. of Post-War Houses erected from 1st April, 1945, to 31st December, 1956.

Housing Programme for 1957.

<u>By Local Authority.</u>	<u>By Private Enterprise.</u>	<u>For Slum Clearance.</u>	<u>For other purposes.</u>
455	166	Nil.	Nil.

(a) No. of temporary housing units occupied - (i) Prefabs. ...	30
(ii) Huts, &c....	3
(b) No. of houses found overcrowded ...	-
(c) No. of houses made fit during year ...	12
<u>Houses required:-</u>	
(i) To replace houses scheduled for demolition ...	15
(ii) To abate overcrowding ...	Nil
(iii) For other purposes ...	Nil
Total number of applications for Council Houses at the end of the year ...	311
Total number of Council houses sold during year ...	Nil

Improvement Grants made under the Housing Act, 1949 - 54.

No. of applications and houses dealt with by Local Authority:-

	<u>Received.</u>		<u>Approved.</u>		<u>Rejected.</u>	
	<u>Applic-</u> <u>-ations.</u>	<u>No. of</u> <u>dwelling.</u>	<u>Applic-</u> <u>-ations.</u>	<u>No. of</u> <u>dwelling.</u>	<u>Applic-</u> <u>-ations.</u>	<u>No. of</u> <u>dwelling.</u>
31/7/49 -						
31/12/55	76	92	59	73	17	19
During year	12	12	12	12	-	-

Note: Number of applications approved in respect of owner/occupiers 5
Average cost per dwelling approved ... £774

APPENDIX D. TABLE 4.

MEAT INSPECTION.

	<u>Cattle</u> <u>excluding</u> <u>Cows.</u>	<u>Cows.</u>	<u>Calves.</u>	<u>Sheep</u> <u>and</u> <u>Lambs.</u>	<u>Pigs.</u>	<u>Horses.</u>
Number inspected ...	327	21	127	619	6	
<u>All diseases except Tuberculosis and Cysticerci.</u>						
		1	5	6	6	
Carcases of which some part or organ was condemned ...	75	3	-	55	37	
Percentage of the number inspected affected with disease other than tuberculosis and cysticerci ...	23%	20%	4.7%	10%	10%	
<u>Tuberculosis only:</u>						
Whole carcasses condemned	1	-	-	-	-	
Carcases of which some part of organ was condemned	22	2	-	-	17	
Percentage of the number inspected affected with tuberculosis ...	7%	10%	-	-	4%	
<u>Cysticercosis</u> ...	-	-	-	-	-	

